
Montana Department of Public
Health & Human Services

**Pandemic
Influenza
Response
Plan**

Draft
7/25/2002

For Additional Information on this Document Contact:

Todd Damrow, PhD., MPH
State Epidemiologist
Montana Department of Health and Human Services
(406) 444-0273
tdamrow@state.mt.us

Michael Spence, MD.
State Medical Officer
Montana Department of Health and Human Services
(406) 444-1286
mspence@state.mt.us

Joyce Burgett, RN
Immunization Program Manager
Montana Department of Health and Human Services
(406) 444-5580
jburgett@state.mt.us

Jim Murphy
Surveillance Coordinator
Montana Department of Health and Human Services
(406) 444-0273
jmurphy@state.mt.us

TABLE OF CONTENTS

Acknowledgments

Introduction	1
Background	
Influenza	3
Pandemic Influenza.	4
Surveillance for Influenza	4
Organization and Responsibilities	
Role of Federal Agencies	6
Role of State Health Department	9
Role of Local Health Departments	13
Authorities and References	16

APPENDICES

Appendix A	Recommendations Regarding the Prioritization of Vaccination . . .	17
Appendix B	Selected Powers and Duties of Local Health Officer and Boards . . .	18
Appendix C	Model Plan Template for Local Health Departments.	20
Appendix D	State Command Structure (Under Development)	23
Appendix E	Mass Immunization Plan Template for local Use (Under Development)	24

I. INTRODUCTION

Influenza viruses are unique in their ability to cause sudden pervasive infection in all age groups on a global scale. The importance of influenza viruses as biological threats is due to a number of factors, including a high degree of transmissibility, the presence of a vast reservoir of novel variants (primarily in aquatic birds), and unusual properties of the viral genome. Rapid rates of evolution in the genes which encode the major antigens of the virus -- the hemagglutinin (HA) and neuraminidase (NA) surface proteins lead to the emergence of annual influenza epidemics which kill, on average, approximately 20,000 Americans. More importantly, segmentation of the virus genome has periodically led to reassortment (exchange) of gene segments between animal and human viruses during chance co-infections, resulting in the sudden and unpredictable emergence of pandemics.

Three such pandemics have occurred in the last 100 years, one of which -- the infamous "Spanish flu" of 1918 -- was responsible for more than 20 million deaths worldwide, primarily in young adults. Although mortality rates associated with the more recent pandemics of 1957 (A/Asia [H2N2]) and 1968 (A/Hong Kong [H3N2]) were reduced in part by antibiotic therapy for secondary bacterial infections and more aggressive supportive care, both were associated with high rates of morbidity and social disruption. Moreover, based on rates of illness and complications observed in these pandemics, the Centers for Disease Control and Prevention (CDC) has preliminarily estimated that economic losses associated with the next pandemic may range from ~\$71 billion to ~\$166 billion, depending on the attack rate.

The impact of an influenza pandemic will depend on how virulent (severe) the virus is, the population affected, how rapidly it can spread from population to population, and the effectiveness of pandemic prevention and response efforts. Using a CDC developed software application (FluAid 2.0) to assess the potential impact of a pandemic in Montana, we estimate

that as many as 330,000 will become ill, 165,000 will seek out-patient treatment, 3,600 will be hospitalized and 850 people will die. If surveillance efforts detect abnormal influenza levels outside the US, Montana may have months to prepare for a disease outbreak. However, if detection of a “novel” virus first occurs in the US we will have much less time to prepare an effective response. Regardless of where originally identified, new influenza cases would expect to continue to occur over a significant period of time, possibly months. Any event would likely impact many areas of the U.S. at once and vaccine and anti-viral drugs may be in short supply.

To prepare for the next pandemic, an event considered by many experts to be inevitable, public health officials from around the world have begun to devise strategies by which influenza-related morbidity, mortality, and social disruption might be reduced. This process was revisited in the U.S. in 1993, when the Federal government convened a panel of experts from the public and private sectors to review and revise the initial plan developed in 1978 and to assess the nation's current capacity to respond to the next pandemic.

This panel of experts not only considered tasks specifically related to the pandemic itself, but also those aimed at reducing the cumulative toll of annual epidemics during the current pre-pandemic period. The panel has emphasized from the outset that State and local health jurisdictions will play critical roles in implementing the national plan, and should actively participate in the planning process.

The purpose of The State of Montana, *Pandemic Influenza Response Plan* developed by the Montana Department of Public Health and Human Services (DPHHS) is to provide a framework for Federal, State and local private and public health care, EMS and medical officials to work together to reduce the influenza morbidity, mortality, and social disruption which would result from a pandemic influenza outbreak. The Plan is a dynamic document that will be periodically updated to reflect new developments in the understanding of the influenza virus, its spread,

treatment, and prevention. The plan will also incorporate changes, as necessary, in response roles and improvements in response capability development through ongoing planning efforts.

II. BACKGROUND

A. Influenza

Influenza is caused by viruses that infect the respiratory tract. Influenza symptoms include rapid onset of fever, chills, sore throat, runny nose, headache, non-productive cough, and body aches. Influenza is a highly contagious illness and can be spread easily from one person to another. It is spread through contact with droplets from the nose and throat of an infected person during coughing and sneezing as well as through hand to hand contact. The time period between exposure and onset of illness is usually one to five days.

There are two types of influenza viruses which cause disease in humans – type A and type B. Influenza A viruses are composed of two major antigenic structures essential to vaccines and immunity: hemagglutinin (H) and neuraminidase (N). The structure of these two components defines the virus sub-type. A minor change, or antigenic drift, caused by mutation results in the emergence of a new strain within a sub-type. Drifts can occur in both type A and B influenza viruses. A major change, or antigenic shift, caused by genetic recombination results in the emergence of a novel sub-type associated with influenza pandemics. This shift occurs with influenza type A viruses. Influenza A viruses are unique because they can infect both humans and animals and cause more severe illness. Antigenic shifts in influenza A viruses have been the cause of at least three pandemics in the 20th century. Detailed information on influenza, including use of vaccine and antiviral medications can be found in *Prevention and Control of Influenza, Recommendations of the Advisory Committee on Immunization Practices (ACIP)* which is updated annually and available from DPHHS (406-444-5580) or the Centers for Disease Control and Prevention website (www.cdc.gov).

B. Pandemic Influenza

Pandemic Influenza is a unique public health emergency or community disaster. Pandemic influenza is considered to be a relatively high probability event, yet no one knows when the next pandemic will occur; there may be very little warning. Most experts believe that we will have between one to six months between the identification of a novel influenza virus and the time that widespread outbreaks begin to occur in the U.S. Outbreaks are expected to occur simultaneously throughout much of the U.S. preventing relocation of human and material resources. The effect of influenza on individual communities will be relatively prolonged - six to eight weeks - when compared to the minutes-to-hours observed in most other natural disasters.

The impact of the next pandemic could have a devastating effect on the health and well-being of the American public. Effective preventive and therapeutic measures - including vaccines and antiviral agents - will likely be in short supply, as may some antibiotics to treat secondary infections. Health-care workers and other first responders could be at even higher risk of exposure and illness than the general population, further impeding the care of victims. Widespread illness in the community will also increase the likelihood of sudden and potentially significant shortages of personnel who provide other essential community services.

C. Surveillance of Influenza

The first line of defense against influenza is a worldwide surveillance system coordinated by the World Health Organization (WHO). This system makes it possible for changes in circulating influenza viruses and the emergence of novel influenza A viruses to be detected as soon as possible. The task of identifying circulating strains of influenza--whether known or novel--is done by a worldwide network of 110 National Influenza Centers and many other WHO laboratories in 83 countries.

Each year, selected influenza virus isolates from state laboratories are submitted to the CDC in Atlanta. Tests are done to determine the antigenic and molecular make-up of the viruses. The CDC examines the viruses to determine which are the most important emerging influenza viruses, and their ability to cause outbreaks, and then provides this information at yearly meetings held by the Food and Drug Administration (FDA) and by WHO so it can be used to formulate vaccine for the next influenza season.

In addition, the CDC actively monitors U.S. disease activity and deaths related to influenza between October and May of each year. This information is provided each week in influenza surveillance summaries.

Montana participates actively in national surveillance activities to help characterize influenza activity at the state and national levels. We rely on selected data sources to track activity throughout the state. Information is used to:

- determine when influenza viruses are circulating, identify circulating strains, and detect changes in the viruses,
- monitor influenza-related illness in Montana,
- implement local control measures (restriction of visitation at health facilities, administration of anti-viral drugs etc.).

Data sources include:

- The Montana Public Health Laboratory and other laboratories conducting testing for influenza,
- Sentinel physicians, comprised of selected practitioners tracking influenza-like illness (fever >100 F AND cough or sore throat),
- County reports of illness as reflected by statewide "activity" reports.

In the event of the identification of a novel virus in the U.S. or abroad, our surveillance efforts would be examined and enhanced as necessary. Possible enhancements would include:

- Encouraging broader culturing of isolates by supporting costs and supplying the necessary collection kits to laboratories throughout the state,
- The addition of hospital based surveillance system for influenza like illness,
- The expansion of the sentinel physician network to ensure more complete representation of the state's population.

III. ORGANIZATION AND RESPONSIBILITIES

A. Federal – Role/Assumptions

1. The Federal government has assumed primary responsibility for a number of key elements of the national plan, including:

- Vaccine research and development ;
- Coordinating national and international surveillance ;
- Assessing and coordinating vaccine and antiviral availability and coordinating public-sector procurement (see Points #3 and 5 below) ;
- Assessing the need for and scope of a suitable liability program for vaccine manufacturers and persons administering the vaccine (see Point #4 below);
- Developing a national "clearinghouse" for vaccine availability information, vaccine distribution and redistribution ;
- Developing an adverse events surveillance system at the national level ;
- Developing a central (national) information database/exchange/clearinghouse on the Internet;
- Developing "generic" guidelines and/or "information templates" that can be modified and/or adapted as needed at the State and local levels, including:
 - Fact sheets/Q & As on influenza, influenza vaccine, and antiviral agents;

- Strategies and guidelines for interacting with the media and communicating effectively with the public health and medical communities and the general public;
- Guidelines for triage and treatment of influenza patients in outpatient, inpatient and non-traditional medical care settings;
- Guidelines for setting up and operating mass vaccination programs;
- Guidelines for distribution and use of antiviral agents;
- Guidelines for the potential utility of "traditional" ("generic") public health measures to curtail transmission such as the use of masks, isolation precautions, quarantine and temporary closure of schools and large businesses.

2. For purposes of consistency, comparability and coordination of the national, state and local response, identification and declaration of the following "stages" will be done at the national level:

Pandemic Phase	Definition
Novel Virus Alert	<ul style="list-style-type: none"> - novel virus detected on one or more humans - little or no immunity in the general population - potential, but not inevitable precursor to a pandemic
Pandemic Alert	- Novel virus demonstrates sustained person-to-person transmission and causes multiple cases in the same geographic area
Pandemic Imminent	- Novel virus causing unusually high rates of morbidity and/or mortality in multiple, widespread geographic areas
Pandemic	- Further spread with involvement of multiple continents; formal declaration made
A Second Wave	- Recurrence of epidemic activity within several months following the initial wave of infection
Pandemic over	- Cessation of successive pandemic "waves", accompanied the return (in the U. S.) Of the more typical wintertime epidemic cycle

3. Because of the substantial lead times required for vaccine production once a novel strain has been identified, it is likely that vaccine will be unavailable, especially during the early phases (6-9 months) of the pandemic. National planners are presently considering which target groups should receive vaccine in priority order (see further discussion below). Moreover, it is expected that individuals will need an initial priming dose followed by a second dose approximately 30

days later to achieve optimal antibody responses and clinical protection. National planners are currently pursuing mechanisms by which influenza vaccine can be made available more rapidly and in larger quantities prior to and during the next pandemic.

4. Liability protection for vaccine manufacturers and persons who administer vaccine is a national issue and may need to be addressed by development of new legislation.

5. Although antiviral agents are available that can theoretically be used for both treatment and prophylaxis during the next pandemic, these agents will likely be available only for limited distribution. In the meantime, national planners are actively pursuing:

- a. The cost and feasibility of stockpiling additional quantities of these drugs and/or their precursors;
- b. The designation of suggested target groups and guidelines for administration;
- c. The cost and feasibility of potential drug distribution schemes; and
- d. The examination of legal and liability issues associated with large-scale distribution.

6. At the present time, limited resources have been made available from the Federal government for purposes of State and local plan development. Based on past history, resources can be expected to made available from the national level for plan implementation, although the level and nature of such resources have not been determined. Aside from new legislation specifically earmarked for planning and response, possibilities include:

- a. Federal contracts for the purchase of influenza vaccine
- b. Federal grants and/or reimbursement for vaccine distribution and administration
- c. Federal purchase of at least some antiviral agents
- d. Federal grants for enhanced surveillance

- e. Release of Federal funds under the Federal Response Plan (Stafford Act; Public Law 93-288, as amended), as is done for other natural disasters (NOTE: criteria to be used for the release of funds have not yet been determined)

Regardless of the options chosen, State and local jurisdictions should, for planning purposes, expect to provide supplementary resources at the time of the pandemic, including temporary redirection of personnel and financial resources from other programs.

B. State Health Department (DPHHS) Role

State government will provide (for counties without a health department) and/or augment public health and emergency medical services that exceed the capabilities of the local government

Pre-Pandemic Phase:

1. Evaluate adequacy of existing state infrastructure to respond to an influenza epidemic.
2. Work with local health care facilities to assess and improve health care worker immunization levels.
3. Review current emergency plans for inclusion of provisions for mass vaccination campaigns. Include security aspects of plan with local, state and federal law enforcement authorities.
4. Assist Local Health Officers/Departments as necessary with conducting a statewide space and site resource inventory. Determine by county the availability and location of shelters, local health clinics, hospitals, national guard armories, schools, gymnasiums, nursing homes, day care centers, and other potential sites for aggregate care. Identify appropriate sites to serve as triage centers, treatment centers, mass vaccination sites or as holding areas for acutely ill patients not able to be admitted to an acute care hospital. Assist Local Health

Officers/Departments with making arrangements with owners of each facility to use the site, if necessary, to care for ill persons during a pandemic.

5. Assist Local Health Officers/Departments as necessary with identifying facilities and resources that may be required in the event of pandemic influenza. Such resources may include identifying and assessing the readiness and availability of; emergency rooms, hospital beds, intensive care unit beds, ventilators, other personal protection equipment masks and gloves, morgue capacity, health care providers, ambulances and field EMS personnel.
6. In coordination with contractors and local health departments, devise a plan for receiving, securing storage, distributing and administering of public sector vaccine.
7. Coordinate pandemic influenza planning with other public health disaster planning at the state level.
8. Establish a means of rapid, two-way communication between the DPHHS and local health departments.
9. Communicate with Law Enforcement and National Guard as to the potential need for protection of vaccine stores and personnel that distribute and administer vaccine.
10. The DPHHS will monitor bulletins from the CDC regarding virologic, epidemiologic and clinical findings associated with new variants isolated within or outside the U.S. and activate sentinel surveillance activities to detect importation and local spread in coordination with CDC. Upon receipt of the Novel Virus Alert information, the Director of Public Health and Human Services will activate the *Pandemic Influenza Response Plan*.
11. The Public Health Disaster Coordinator will contact the Montana Disaster and Emergency Services Agency (DES) and advise of the CDC's issuance of the

Novel Virus Alert. In addition, the Public Health Disaster Coordinator will update DES regarding any related activities planned and/or initiated by DPHHS.

12. The DPHHS public health laboratory manager will advise laboratory staff to obtain appropriate reagents to detect and identify the novel strain when they become available from the CDC. Staff will notify clinical lab service providers regarding the availability of the testing and protocols describing specimen collection and submission.
13. The DPHHS Immunization Section Manager will instruct staff to perform the following preparedness activities:
 - a. Review and recommend modifications as needed to the *Pandemic Influenza Response Plan*,
 - b. Review and modify as needed the antiviral and vaccine distribution plan,
 - c. Review and recommend a prioritization of target groups to received antiviral and vaccine supplies, based upon the CDC and WHO inventory projections. See Appendix A for guidance on prioritization of target groups.
14. The DPHHS will communicate with local health departments via the Health Alert Network (HAN) and appropriate partners and stakeholders information on the Novel Virus Alert, activation of the *Pandemic Influenza Response Plan* and implementation of sentinel surveillance activities.

DPHHS Communications

The DPHHS Public Information Officer (PIO) will assist DPHHS Director and other staff with the coordination of pandemic influenza response activities within DPHHS. The PIO will direct

all communications with the public and media agencies with input from the above individuals and coordinate the release of information, as needed, with the Disaster and Emergency Services Emergency Operations Center (EOC) and Governor's Communications Office. The PIO may also assist local health departments as needed with communications consultation. In response to the activation of the DPHHS *Pandemic Influenza Response Plan*, the information officers duties will consist of:

1. Attending briefings and assist the EOC Communications Officer and the Public Health Disaster Coordinator with planning and implementing an 800 number for rumor control and information for the general public. The hotline will be controlled and operated by DPHHS staff. The Public Information Officer will assist in assembling informational materials for hot line staff to use as reference.
2. Direct media and public communications for the DPHHS/EOC; attend briefings on a regular basis, and/or maintain close contact with the State Epidemiologist and Medical Officer to obtain updated information.
3. Relay new information to the public and media on a timely basis; arrange press briefings as needed; develop a process for hot line staffers to obtain all new information.
4. Coordinate releases with the Health Alert Network Coordinator to assure consistent information is released on the website and with Health Alert distributions.
5. Post on the DPHHS web site, www.dphhs.state.mt.us press releases and public information fact sheets regarding the Pandemic Alert. Distribute the same to media.
6. Continue to update information for the rumor control/information hotline for the general public until the volume of calls indicates it can be deactivated and calls can be handled via normal business operations.

Utilization of Other State Agencies

Other State Agencies would be activated through the State Emergency Coordination Plan (ECP) when the capacity of DPHHS to respond is exceeded. The Public Health Disaster Coordinator, through the DES point of contact, would request assistance through the DES Duty Officer. Agency roles in disaster response are identified in the Emergency Coordination Plan.

C. Local Health Departments

Local health departments, under the direction and authority of a local health officer, have the primary responsibility of planning and implementing the community-wide response to health threats. General activities of the local health department staff include:

1. Promotion of vaccinations to prevent disease.
2. Distribution of vaccine to public and private providers community-wide.
3. Surveillance of preventable adult and childhood diseases.
4. Provision of educational and motivational resources through community partnerships.
5. Assessment of vaccine coverage levels.
6. Quality assurance reviews of federally purchased vaccine.

Specific responsibilities of local health agencies related to pandemic influenza preparation include:

Pre-Pandemic Phase:

1. Evaluate adequacy of existing local infrastructure to respond to an influenza epidemic.
2. Review local health department and emergency/disaster policy and procedures to find and remove any barriers to the annual influenza or

pneumococcal vaccination programs. Work with local health care facilities to assess and improve health care worker immunization levels.

3. Review current emergency plans for inclusion of provisions for mass vaccination campaigns. Include security aspects of plan with local, state and federal law enforcement authorities.
4. Conduct a county-wide/health district-wide space and site resource inventory. Determine the availability and location and capacity of shelters, local health clinics, hospitals, national guard armories, schools, gymnasiums, churches, nursing homes, day care centers, and other potential sites for aggregate care. Identify appropriate sites to serve as triage centers, treatment centers, mass vaccination sites or as holding areas for acutely ill patients not able to be admitted to an acute care hospital. Make arrangements with owners of each facility to use the site, if necessary, to care for ill persons during a pandemic.
5. Conduct a county-wide/health district-wide survey of hospitals, emergency departments and EMS capacity, including number and location of hospital beds, availability of laboratory services, intensive care unit beds, ventilators, other personal protection equipment (i.e. masks and gloves), morgue capacity, health care providers, ambulances available and field EMS personnel available.
6. In coordination with DPHHS, devise a plan for safely accepting, storing, and distributing of public sector vaccine and antiviral medications.
7. Educate staff and community about the nature and significance of pandemic influenza and the federal, state and local response.
8. Work with local private and volunteer organizations to develop and coordinate the local response to a flu pandemic.

9. Through contact with DPHHS, coordinate pandemic influenza planning with other public health disaster planning at the local and regional levels.
10. With the assistance of DPHHS through HAN or other resources, establish a means of rapid, two-way communication with local health officers, EMS service managers, hospital emergency departments, local veterinarians, and hospital administrators, and other local emergency/disaster agency stakeholders .

Pandemic Phase:

Local health departments will communicate through their Health Alert Network or other available resources, to infection control practitioners, hospitals, and health care providers information on the Pandemic outbreak and implement local response procedures as designated in local preparedness plans. They will also maintain ongoing contact with DPHHS to receive updates regarding the status of the pandemic and state and national control efforts.

Local health department staff will implement vaccination and drug distribution and administration using the Mass Prophylaxis Protocol (model plan to be developed by DPHHS). When necessary, local health department staff will coordinate vaccine drug distribution activities with bordering jurisdictions. During all stages of the pandemic event, local health agencies will maintain communication with infection control practitioners, hospitals, EMS, public safety and other health care providers.

Local Health Officers are legally responsible for pandemic influenza response activities under the direction of their local board of health. A summary of powers and duties of local health department directors has been listed in Appendix B.

Authorities and References

Centers for Disease Control and Prevention National Vaccine Program Office: Pandemic Influenza: A Planning Guide for State and Local Officials, (Draft 2.1), April 7, 2001

Centers for Disease Control and Prevention, Epidemiology and Prevention of Vaccine-Preventable Diseases, 6th Edition, January, 2000, pp. 231-235

Centers for Disease Control and Prevention, Emerging Infectious Diseases web site, Preparing for Pandemic Influenza, www.cdc.gov/ncidod/eid/vol5no3/work.htm

Centers for Disease Control and Prevention and Council of State and Territorial Epidemiologists, State Pandemic Planning Meeting and Pandemic Tabletop Exercise, Atlanta, Ga., September 12-13, 2000

Centers for Disease Control and Prevention, National Immunization Program, Live Satellite Broadcast, "Update: Preparing for the Next Influenza Pandemic", July 13, 2000

Council of State and Territorial Epidemiologists, National Vaccine Program Office, Pandemic Influenza Table Top Exercise, CD-Rom, Freeware

The World Health Organization web site, (revised) Pandemic Influenza Stages, www.who.int/emc?documents/influenza/whocdscsredc99/c.html

The World Health Organization web site, The Role of the World Health Organization, www.who.int/emc-documents/influenza/docs/index.htm/sec3.htm

The World Health Organization web site, The Role of National Health Authorities and Pandemic Planning Committees, www.who.int/emc-documents/influenza/docs/index.htm/sec4.htm

Prevention and control of influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2001;50(no. RR-4).

FluAid 2.0, *A specialized software that estimates the number of deaths, hospitalizations, and outpatient visits that may occur during the next pandemic*. September 1, 2000, CDC, National Vaccine Program Office.

Recommendations Regarding the Prioritization of Vaccination

Category 1	<p>Groups at highest risk for serious influenza-related complications, including:</p> <ul style="list-style-type: none"> • First Responders and Emergency Medical Service Personnel • Physicians, nurses, and other staff in hospital and outpatient settings who provide direct patient care. • Household members (including children) of persons in the above high risk groups. • Law enforcement Officers and/or National Guard protecting the vaccine stores and/or the personnel distributing and administering vaccine. • Health care workers and public health personnel involved in the distribution of vaccine and antiviral agents • Persons responsible for community safety and security, e.g., police, firefighters, military personnel, National Guard, "first responders" not included in first priority group (e.g., ambulance drivers) • Other highly skilled persons who provide essential community services whose absence would either pose a significant hazard to public safety (e.g., nuclear power plant workers) or severely disrupt the pandemic response effort (e.g., persons who operate regional telecommunications or electric utility grids, snow plow operators during winter conditions). [NOTE: Members of this target group are likely to vary widely from jurisdiction to jurisdiction, depending on local circumstances.] <p>The priority of immunization of the individuals listed below may vary dependent upon the group at highest risk (i.e. the 1918 Influenza Pandemic was a disease of healthy young adults and children and the elderly were for the most part spared).</p> <ul style="list-style-type: none"> • Persons 65 years of age or older. • Residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions. • Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including children with asthma. • Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications). • Children and teenagers (age 6 months to 18 years) who are receiving long-term aspirin therapy that might put them at risk for developing Reye=s syndrome after influenza. • Women who will be in the second or third trimester of pregnancy during the influenza season.
Category 2	<p>Those persons who provide direct care to persons in category 1, including:</p> <ul style="list-style-type: none"> • Employees of nursing homes and chronic-care facilities who have direct contact with patients or residents. • Employees of assisted living and other residences for persons in high-risk groups who provide direct care. • Providers of home care to people at high risk (e.g., visiting nurses and volunteer workers). • Household contacts of persons with high-risk medical conditions
Category 3	<p>Otherwise healthy persons age 6 months and older who wish to reduce their likelihood of becoming ill with influenza, such as:</p> <ul style="list-style-type: none"> • Students and other persons in institutional settings (e.g., college students in dormitories). • Employees of health care facilities who do not provide direct patient care. • Persons who provide essential community services. • Healthy persons in the workplace. • Others.

Selected Powers and Duties of Local Health Officer and Boards.

The excerpts below are not intended to outline all the responsibilities and powers of local health boards and/or local health officers. Additional statutes and Administrative Rules of Montana may grant additional authorities and responsibilities.

50-2-116. Powers and duties of local boards. (1) Local boards shall:

(a) appoint a local health officer who is a physician or a person with a master's degree in public health or the equivalent and with appropriate experience, as determined by the department, and shall fix the health officer's salary;

(b) elect a presiding officer and other necessary officers;

(c) employ necessary qualified staff;

(d) adopt bylaws to govern meetings;

(e) hold regular meetings quarterly and hold special meetings as necessary;

(f) supervise destruction and removal of all sources of filth that cause disease;

(g) guard against the introduction of communicable disease;

(h) supervise inspections of public establishments for sanitary conditions;

(i) subject to the provisions of 50-2-130, adopt necessary regulations that are not less stringent than state standards for the control and disposal of sewage from private and public buildings that is not regulated by Title 75, chapter 6, or Title 76, chapter 4. The regulations must describe standards for granting variances from the minimum requirements that are identical to standards promulgated by the board of environmental review and must provide for appeal of variance decisions to the department as required by 75-5-305.

(2) Local boards may:

(a) quarantine persons who have communicable diseases;

(b) require isolation of persons or things that are infected with communicable diseases;

(c) furnish treatment for persons who have communicable diseases;

(d) prohibit the use of places that are infected with communicable diseases;

(e) require and provide means for disinfecting places that are infected with communicable diseases;

(f) accept and spend funds received from a federal agency, the state, a school district, or other persons;

(g) contract with another local board for all or a part of local health services;

(h) reimburse local health officers for necessary expenses incurred in official duties;

(i) abate nuisances affecting public health and safety or bring action necessary to restrain the violation of public health laws or rules;

(j) adopt necessary fees to administer regulations for the control and disposal of sewage from private and public buildings. The fees must be deposited with the county treasurer.

(k) adopt rules that do not conflict with rules adopted by the department:

(i) for the control of communicable diseases;

(ii) for the removal of filth that might cause disease or adversely affect public health;

(iii) subject to the provisions of 50-2-130, on sanitation in public buildings that affects public health;

(iv) for heating, ventilation, water supply, and waste disposal in public accommodations that might endanger human lives;

(v) subject to the provisions of 50-2-130, for the maintenance of sewage treatment systems that do not discharge an effluent directly into state waters and that are not required to have an operating permit as required by rules adopted under 75-5-401; and

(vi) for the regulation, as necessary, of the practice of tattooing, which may include registering tattoo artists, inspecting tattoo establishments, adopting fees, and also adopting sanitation standards that are not less stringent than standards adopted by the department pursuant to 50-1-202. For the purposes of this subsection, "tattoo" means making permanent marks on the skin by puncturing the skin and inserting indelible colors.

(l) adopt regulations for the establishment of institutional controls that have been selected or approved by the:

(i) United States environmental protection agency as part of a remedy for a facility under the federal Comprehensive Environmental Response, Compensation, and Liability Act of 1980, 42 U.S.C. 9601, et seq.; or

(ii) department of environmental quality as part of a remedy for a facility under the Montana Comprehensive Environmental Cleanup and Responsibility Act, Title 75, chapter 10, part 7.

50-2-118. Powers and duties of local health officers. (1) Local health officers or their authorized representatives shall:

- (a) make inspections for sanitary conditions;
- (b) as directed by the local board, issue written orders for the destruction and removal of filth which might cause disease;
- (c) with written approval of the department, order buildings or facilities where people congregate closed during epidemics;
- (d) on forms provided by the department, report communicable diseases to the department each week;
- (e) before the first day of January, April, July, and October, give a report to the local board of sanitary conditions in the county, city, city-county, or district, together with a detailed account of his activities, on forms and containing information required by the department;
- (f) before the 10th day after the report is given to the local board, send a copy of the report required by subsection (1)(e) of this section to the department;
- (g) as prescribed by rules adopted by the department, establish and maintain quarantines;
- (h) as prescribed by rules adopted by the department, supervise the disinfection of places at the expense of the local board when a period of quarantine ends;
- (i) notify the department of his appointment and changes in membership of the local board;
- (j) file a complaint with the appropriate court if this chapter or rules adopted by the local board or state department under this chapter are violated;
- (k) validate state licenses issued by the department in accordance with chapters 50 through 53 of this title.

(2) With approval of the department, local health officers may forbid persons to assemble in a place if the assembly endangers public health.

(3) A local health officer who is a physician may be placed in charge of a communicable disease hospital, but a local health officer who is a physician is not required to act as a physician to the indigent.

(4) A local health officer who is not a physician shall not act as a physician to anyone.

History: En. Sec. 87, Ch. 197, L. 1967; amd. Sec. 2, Ch. 196, L. 1971; amd. Sec. 56, Ch. 349, L. 1974; R.C.M. 1947, 69-4510; amd. Sec. 1, Ch. 200, L. 1979; amd. Sec. 18, Ch. 708, L. 1991.

50-2-120. Assistance from law enforcement officials. A state or local health officer may request a sheriff, constable, or other peace officer to assist him in carrying out the provisions of this chapter. If the officer does not render the service, he is guilty of a misdemeanor and may be removed from office.

History: En. Sec. 90, Ch. 197, L. 1967; R.C.M. 1947, 69-4513; amd. Sec. 1, Ch. 37, L. 1979.

50-2-122. Obstructing local health officer in the performance of his duties unlawful. It is unlawful to:

- (1) hinder a local health officer in the performance of his duties under this chapter;
- (2) remove or deface any placard or notice posted by the local health officer; or
- (3) violate a quarantine regulation.

History: En. Sec. 94, Ch. 197, L. 1967; R.C.M. 1947, 69-4517.

Cross References:

Obstructing peace officer or other public servant, 45-7-302.

Penalties for violations, 50-2-124.

50-2-123. Compliance order authorized. If a person refuses or neglects to comply with a written order of a state or local health officer within a reasonable time specified in the order, the state or local health officer may cause the order to be complied with and initiate an action to recover any expenses incurred from the person who refused or neglected to comply with the order. The action to recover expenses shall be brought in the name of the city or county.

History: En. Sec. 96, Ch. 197, L. 1967; amd. Sec. 108, Ch. 349, L. 1974; amd. Sec. 3, Ch. 273, L. 1975; R.C.M. 1947, 69-4519(1).

COUNTY HEALTH DEPARTMENT PANDEMIC INFLUENZA PLAN TEMPLATE

County: _____ 24 hour contact phone number _____

Name of person responding _____

A. Specific Activities of Local Health Department	List Staff Currently Responsible
1. Promotion of vaccinations for disease Prevention	
2. Distribution of vaccine to public and private providers in community.	
3. Surveillance for preventable adult and childhood diseases.	
4. Provision of educational and motivational resources through community partnerships.	
5. Assessment of vaccine coverage levels.	
6. Quality assurance reviews of federally Purchased vaccine.	

B. Local Health Department Pre-Pandemic Phase Activities	Indicate Staff Assigned
1. Evaluate existing local infrastructure to respond to influenza epidemic.	
2. Review local department and emergency/disaster policy and procedures to find and remove barriers <ul style="list-style-type: none"> a. Influenza and pneumococcal vaccination program b. Survey of local health care worker immunization levels 	
3. Review current local emergency plans <ul style="list-style-type: none"> a. Mass vaccination campaign plans b. Provide for security for mass vaccination campaign (local/state) 	
4. Conduct an inventory county-wide of space	

<p>and site capacity to serve as triage centers, treatment centers, mass vaccination sites or holding areas for acutely ill patients. Include capacity and address of each site.</p> <ul style="list-style-type: none"> a. Local health clinics b. Hospitals c. National guard armories d. Schools e. Gymnasiums f. Nursing homes g. Day care centers h. Churches i. Other <p>Make arrangements with owners of each facility for use of sites if necessary.</p>	
<p>5. Survey of hospitals, emergency departments and EMS capacity</p> <ul style="list-style-type: none"> a. Number and location of hospital beds b. Number and location of intensive care unit beds c. Number and location of ventilators d. Location of masks/gloves for personal protection e. Number of health care providers and how to contact f. Number and location of ambulances g. Number and how to contact EMS personnel 	
<p>6. Determine local morgue capacity. Identify facilities/resources with refrigerated storage to serve as temporary morgues if necessary.</p>	
<p>7. Develop plan for accepting, storing, and distributing public sector vaccine and antiviral medications, in coordination with DPHHS Immunization Program.</p>	

8. Educate medical community and general population about nature and significance of pandemic influenza, the federal, state and local responsibilities.	
9. Develop and synchronize local county response to a flu pandemic with private and volunteer organizations, (i.e. physicians, physician assistants, nurse practitioners, service clubs such as Rotary, Jaycees, and faith-based organizations)	
10. Coordinate planning with other public health departments in region.	
11. Coordinate HAN or other communication resources with local health officers, EMS managers, hospital emergency departments, local veterinarians, hospital administrators and other local emergency/disaster agency stakeholders.	

B.

C. C. An updated list of phone numbers, fax numbers and/or e-mail addresses available for local use can be found : _____.

Local physical location of list indicated on line above

State command Structure- Under Development

Appendix E.

Mass Immunization Plan Template- to be developed.